T BAR M CHALLENGE COURSE PROGRAMS MEDICAL QUESTIONNAIRE

To be filled out by participant or parent/guardian if under 18:

Note: complete individual forms for each retreat participant (camper or day guest)

Name of participant: _____ Sex: _____
Birthdate: _ _ / _ _ / _ _ _ _
Home Address: _____
City: _____ State: _____ Zip: _____

In an emergency notify: _____ Phone: ( ) _____
Relationship: _____

Participant Medical History
Health History: (Circle the appropriate response and describe any yes answers)

Have you had or do you currently have any heart problems?
i.e., strokes, heart attacks, and/or heart related diseases? YES NO
_____

Do you frequently suffer from pains/pressure in your chest? _____ YES NO
Do you often feel faint or have spells of severe dizziness? _____ YES NO
Has a doctor ever told you that you have high blood pressure? _____ YES NO
Are you a smoker? _____ YES NO
(NOTE: If you have had any heart related problems you will need to have a release from a physician in order to participate in any camp activities.)
Do you have arthritis, joint or back problems that might be aggravated by exercise?
_____ YES NO
Have you had any operations, serious injuries or illnesses?
(dates)_____ YES NO
Do you have any disabilities or communicable diseases? _____ YES NO
Are you allergic to any medicines, insects or pollen? _____ YES NO
Are you allergic to any foods? _____ YES NO
Do you have Asthma? _____ YES NO
Do you have Epilepsy? _____ YES NO
Do you have Diabetes? _____ YES NO
Do you have any prescribed meal plan or restrictions? _____ YES NO
Are you currently sick and/or using a medication not listed above? _____ YES NO
List any activities to be limited or prohibited

_____
Suggestions or health related information for T Bar M Camps Personnel:

_____
General Health Statement (How is your health today?)

_____
Additional Information or Comments: _____

_____

_____
Are you covered under hospitalization insurance?

Carrier_____ Policy # _____

In the event that I am unable to grant permission, I do give permission to the physician selected by the group leader to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for me.
Participant Name: _____
Participant/Parent Guardian Signature: _____Date: _____